## Introduction

This manual is for use by providers, their accountants, the Division of Medicaid, and its fiscal agent in determining the allowable and reasonable costs of long-term care services furnished to Medicaid recipients. The manual contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Division of Medicaid. These procedures will be used in determining the payment to the provider of its allowable and reasonable costs. The payment to nursing facility providers only will be under a case-mix reimbursement system.

The program herein adopted is in accordance with Federal Statute, 42 U.S.C.A., section 1396a(A)(13) and (28). The applicable Federal Regulations are 42 CFR 447, subparts B and C and 42 CFR 483, subparts B and D. Each long-term care facility which has contractually agreed to participate in the Title XIX Medical Assistance Program will adopt the procedures set forth in this manual; each must file the required cost reports and will be paid

for the services rendered on a rate related to the allowable and reasonable costs incurred for care and services provided to Medicaid recipients. Payments for services will be on a prospective basis.

In adopting these regulations, it is the intention of the Division of Medicaid to pay the allowable and reasonable costs of covered services and establish a trend factor to cover projected cost increases for all long-term care providers. For nursing facility providers only, the Division of Medicaid will include an adjustable component in the rate to cover the cost of service for the facility specific case-mix of residents as classified under the Multi-State Medicare Medicaid Payment Index ($M^3PI$). While it is recognized that some providers will incur costs in excess of the reimbursement rate, the objective of this plan is to reimburse providers at a rate that is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated nursing facilities that comply with all requirements of participation in the Medicaid program.

As interpretations and changes of this plan are made, appropriate revisions of this manual will be furnished to each provider and

interested parties. Care should be taken to insure that revisions to the manual are promptly inserted.

Questions related to this reimbursement plan or to the interpretation of any of the provisions included in this manual should be addressed to:

Division of Medicaid
Suite 801, Robert E. Lee Building
239 North Lamar Street
Jackson, Mississippi 39201-1399

# CHAPTER 1

# PRINCIPLES AND PROCEDURES

## 1-1 General Principles

A facility's direct care costs, therapy costs, care related costs, administrative and operating costs and property costs related to covered services will be considered in the findings and allocation of costs to the Medical Assistance Program for its eligible recipients. Costs included in the per diem rate will be those necessary to be incurred by efficiently and economically operated nursing facilities that comply with all requirements of participation in the Medicaid program with the exception of services provided that are reimbursed on a fee for service basis or as a direct payment outside of the per diem rate.

## 1-2 Classes of Facilities

Specific classes are used as a basis for evaluating the reasonableness of an individual provider's costs. The classes consist of Small Nursing Facilities (1 - 60 beds), Large Nursing Facilities (61 or more beds), Residential Psychiatric Treatment Facilities (PRTF), and Intermediate Care Facilities for the Mentally Retarded (ICF-MR).

1-3 Cost Reporting

A. Reporting Period

All Nursing Facilities, PRTF's, and ICF-MR's shall file cost reports based on a standard year end as prescribed by the provisions of this plan. State owned facilities shall file cost reports based on a June 30 year end. County owned facilities shall file cost reports based on a September 30 year end. All other facilities shall use a standard year end of December 31. Standard year end cost reports should be filed from the date of the last report. Facilities may request to change to a facility specific cost report year end, if the requested year end is the facility's Medicare or corporate year end.

Other provisions of this plan may require facilities to file a cost report for a period other than their standard reporting year. Facilities which previously filed a short period cost report that includes a portion of their standard reporting year must file a cost report for the remainder of their standard reporting year, excluding the short period for which a report was previously required. For example, a facility that has a standard reporting year of January 1 through December 31 and undergoes a change of ownership on April 1, would be required to file the following cost reports:

1. a final cost report for the seller for the period January 1 through March 31;

2. an initial cost report for the buyer would be required per Section 1-3, M, for the period April 1 through June 30; and

3. a regular year-end cost report for the buyer for the period July 1 through December 31.

B. When to File

Each facility must submit a completed cost report, in duplicate, on or before the last day of the fifth month following the close of the reporting period. Should the due date fall on a weekend, a State of Mississippi holiday or a federal holiday, the due date shall be the first business day following such weekend or holiday.

C. Extension for Filing

Extensions for filing cost reports will not be granted.

D. Delinquent Cost Reports

Cost reports that are either postmarked or hand delivered after the due date will be assessed a penalty in the amount of $50.00 per day the cost report is delinquent. This penalty may only be waived by the Director of the Division of Medicaid.

E. What to Submit

All cost reports must be filed in duplicate with copies of the following:

(1) Working Trial Balance, facility and home office (if applicable), (2 copies);

(2) Depreciation Schedule(s). If the facility has different book and Medicaid depreciation schedules, copies of both depreciation schedules must be submitted. If the facility has home office costs, copies of the home office depreciation schedule must also be submitted, (2 copies);

(3) Any work papers used to compute adjustments made in the cost report, (2 copies);

(4) Narrative description of purchased management services or a copy of contracts for managed services, if applicable, (2 copies);

(5) Narrative description or a copy of contracts of management services provided by a related party or home office and one of the following (a) a detailed statement of total costs with adjustments for non-allowable costs that includes all the line items on Form 17 and a description of the basis used to allocate the costs to providers of the group and to non-provider activities, if applicable or (b) a completed Form 17, (2 copies).

The two copies of the cost report filed with the Division of Medicaid must have original signatures on the Certification by Officer or Administrator of Provider (Form 2) and on the Owners' Compensation forms (Form 15).

When it is determined, upon initial review for completeness by the Division of Medicaid, that a cost report has been submitted that is not complete enough to perform a desk review, the provider will be notified. The provider must submit a complete cost report. If the request is made and the completed cost report is not received on or before the due date of the cost report, the provider will be subject to the penalties for filing delinquent cost reports. When it is determined that the cost report submitted is complete but is missing certain information, providers will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit

the additional information. For cost reports which are submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information will be made. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. Information that is requested that is not submitted following either the first or the second request may not be submitted for reimbursement purposes. Providers will not be allowed to submit the information at a later date, at the time of audit, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Allowable costs will be adjusted to disallow any expenses or cost findings that are not submitted.

F. Where to File

The cost report and related information should be mailed to:

Reimbursement Division
Division of Medicaid
Office of the Governor
Suite 801, Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201-1399

G. Cost Report Forms

All cost reports must be filed using forms and instructions that

are adopted by the Division of Medicaid. Providers which submit computerized forms must have the format of the form approved by the Division of Medicaid reimbursement staff in advance of submitting any cost reports. New approval must be obtained each time the cost report forms are changed by the DOM.

H. Amended Cost Reports

The Division of Medicaid accepts amended cost reports for a period of eighteen (18) months following the end of the reporting period. Amended cost reports should include two (2) copies of Form 1 in order to explain the reason for the amendment in Section II, Form 2 with original signatures on both copies, and all forms that are being amended in duplicate. Each form and schedule submitted should be clearly marked "Amended" at the top of the page. Amended cost reports submitted after the annual base rate is determined will be used only to adjust the individual provider's rate, if necessary. Cost reports may not be amended after an audit has been initiated.

I. Desk Reviews

The Division of Medicaid will conduct a review of the cost report prior to the rate determination. The objective of the desk review is to determine the necessity and reasonableness of facility costs in order to determine the allowable costs used in the calculation of the prospective per diem rate.

The desk review will be performed using a desk review program developed by the Division of Medicaid. Providers will be notified, in writing, of all adjustments made to allowable costs.